Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumers	)	WC Docket No. 18-213
	)	

COMMENTS OF GILA RIVER TELECOMMUNICATIONS, INC.

Gila River Telecommunications, Inc. ("GRTI"), by its attorneys, hereby submits these comments in the above-referenced proceeding in which the Federal Communications Commission ("FCC" or "Commission") seeks comment on establishment of a Pilot program within the Universal Service Fund (USF) to support connected care for low-income Americans and veterans.[1] GRTI is pleased the Commission has moved forward with the NPRM and is generally supportive of the proposal outlined in it. In this filing, GRTI provides brief comment on elements of the proposal focused on the structure of the program, budgetary concerns, and the application selection criteria.[2]

Structure of the Program. GRTI is generally supportive of the proposed structure of the program and agrees with the Commission's definition of "connected care" as a subset of telehealth focused on delivering remote medical, diagnostic, and treatment-related services, where "telehealth" is defined as encompassing a wide variety of remote health care services

[1] *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Proposed Rulemaking, FCC 19-64 (July 11, 2019) ("*Connected Care NPRM*").

[2] These comments build on the comments filed by GRTI to the Notice of Inquiry in this proceeding. GRTI comments, WC Docket No. 18-213, filed Sept. 11, 2018, available at https://ecfsapi.fcc.gov/file/10910205911792/Gila%20RIver%20Telecommunications%20comments%20Connected%20Care%20Pilot%20Program.pdf ("*GRTI NOI comments*").

provided by a range of health care providers.[3] Ensuring a broader scope of the types of services eligible for support in the Connected Care Pilot Programs will help better inform the Commission's understanding of the importance of providing support through the Universal Service Fund for these services.

GRTI reiterates its support for both fixed and mobile connectivity opportunities to be supported through the Pilot program.[4] Different technologies and applications likely demand different types of connectivity. Internet-of-Things (IoT) devices relaying patients' vitals or other short data bursts can flow over wireless networks whereas consultations and diagnostic services may best be conducted over fixed networks. As such, the Connected Care Pilot program should provide opportunities for both technologies and even allow eligible health care providers to bundle these technologies as part of their applications.

GRTI would caution the Commission against adopting structural rules that have the effect of favoring "single purpose" connectivity over broadband Internet access services.[5] In the NPRM, the Commission seeks comment on whether health care providers should limit their offerings to connectivity that enables access to the Internet for health care purposes.[6] The Commission also seeks comment on whether it should require participants to allocate cost "for services or other items supported through the Pilot program that are used for non –health care purposes or include ineligible components" citing as an example requiring "cost allocation of the non-health care usage" of broadband service.[7] Such an allocation would create a substantial

[3] *Connected Care NPRM* at para. 21.
[4] *Id*. at para. 19; *GRTI NOI comments* at 13-14.
[5] 47 C.F.R. § 8.1.
[6] *Connected Care NPRM* at para. 22.
[7] *Id*. at para. 34.

burden for health care providers (or more likely the broadband internet access service providers) because there would be a need to adopt tools to assist in monitoring and tracking traffic to make effective cost allocations. Moreover, such a requirement would introduce unnecessary complexity given the marginal cost associated with carrying any additional traffic over a broadband connection. While the E-Rate program requires cost allocation for ineligible services and components, that program provides ongoing support and is a permanent component of USF.[8] Here, the Pilot program is envisioned as a "proof of concept" mechanism designed to help the Commission determine whether and how a permanent program might fit within the framework of the existing Rural Health Care program.[9]

Further, regarding support for end-user devices, GRTI would urge the Commission to reconsider its proposal to exclude from support funding for end-user devices.[10] While it may very well be the case that states and larger federal entities like those cited by the Commission to support its proposal are capable of securing funding from other sources for the purchase of these devices, health care providers offering services to low-income families likely are not able to find such funding.[11] At a minimum, the Commission should consider as part of the application process affording eligible health care providers an opportunity to demonstrate their need for funding under the Pilot program to cover the cost of end-user devices.[12]

Budget. GRTI supports the proposed $100 million budget for the Pilot program.[13] By incorporating a program discount level of 85 percent, the Commission would effectively extend

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[8] 47 C.F.R. § 54.504.

[9] *Connected Care NPRM* at 28 (*proposing* $100 million in funding for three years).

[10] *Id.* at para. 26.

[11] *Id.* at n. 53.

[12] *GRTI NOI comments* at 14.

[13] *Connected Care NPRM* at para. 28.

the potential reach of the program to include more participants.[14] Should the Commission decide to adopt a cap for the monthly amount of support that can be paid for broadband Internet access service, GRTI would propose the cap be determined by benchmarks previously established by the Commission, *e.g*. Alternative Connect America Cost Model benchmark.[15]

The Commission should be mindful of the fact that the target recipients for connected care under the Pilot program are low-income and veteran families. These families face budgetary challenges in not only affording health care, but in affording necessities. As such, the Commission should not consider "participating patients as an eligible source of the non-discounted share for services under the Pilot program."[16] As GRTI has demonstrated in past filings before the Commission, Tribal communities in particular face higher poverty rates and unemployment rates, facts that the Commission should consider as it designs Pilot program rules.[17]

Project Selection. GRTI supports the Commission's proposal not to limit the number of projects funded and to provide for flexible project funding levels as proposed in the NPRM.[18] The Commission must ensure that a wide range of projects are funded and thus should opt not to fund only a handful of large projects.[19] The Commission acknowledges the importance of this in its proposal to "promote a selection of a diverse range of projects…where there are well-documented health care disparities (Tribal lands, rural areas, or veteran populations)."[20] In this

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[14] *Id.* at para. 31.

[15] GRTI comments at 11, WC Docket No. 11-42, filed Sept. 2 2015, available at https://ecfsapi.fcc.gov/file/60001223334.pdf.

[16] *Connected Care NPRM* at para. 32.

[17] *Supra* n. 15 at 4.

[18] *Connected Care NPRM* at para. 33.

[19] *Id*. at para. 33.

[20] *Id*. at para. 56.

regard, GRTI would caution against limiting the scope of projects to areas that are designated by the Health Resources and Services Administration as Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA) as those programs may exclude areas that would otherwise be areas of interest as the Commission establishes this Pilot program.[21] As GRTI has learned over the years, often well-intentioned opportunities to identify specific areas of need have not been adequately targeted for outreach to Tribal communities and thus those Tribal communities are not part of the programs. Absent the Commission verifying that the HPSA and MUA programs are a complete dataset of potential participants, relying on them to exclude potential participants could unnecessarily exclude otherwise worthy projects.

Similarly, GRTI disagrees with the Commission's proposal requiring health care providers to have prior experience with telehealth and long-term patient care.[22] A goal of the Pilot program is to reach communities that have not enjoyed the benefits of the innovative technologies that have developed for connected care.[23] Requiring prior experience for a health care provider would likely eliminate from consideration clinics and other health care providers that serve rural, Tribal and low-income communities that have not had the means to participate in telehealth services. Health care providers seeking to participate can leverage either staff-level experience or services from entities that are experienced in providing these services to ensure their projects conform with any program rules the Commission adopts.

[21] *Id.* at para. 43.
[22] *Id*. at para. 40.
[23] *Id.* at para. 1.

As set forth above, GRTI is generally supportive of the Commission's proposal to establish a Connected Care Pilot program. GRTI is eager to work with the Commission and other stakeholders to address the concerns raised in these comments and may have additional concerns based on comments filed by others in response to the NPRM. As GRTI outlined in its initial comments to this proceeding, the Gila River Indian Community suffers from one of the highest rates of diabetes in the world and is eager to participate in the ultimate Pilot program adopted as part of this proceeding so the benefits of innovative telehealth technologies can be brought to bear to address diabetes and other ailments suffered by members of the Community GRTI is charged with serving.

Respectfully Submitted,
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